RAJIV M. JOSEPH, M.D., Ph.D., F.A.A.N.
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CONSENT FOR TREATMENT

I, ____, acknowledge the need for medical care and hereby request and voluntarily consent to receive the usual medical services as well as the diagnostic procedures and medical treatment. **I understand that there is no guarantee as to the outcome or results of the treatments or examinations received.**

**Please provide our office with 48 hours notice if you must cancel testing ordered or you may be subject to a $100 cancellation fee.*

CONFIDENTIALITY

I understand that any and all medical care that I receive at the office of Rajiv Joseph, MD, PA will be treated with the utmost confidentiality. However, to facilitate my medical care I hereby authorize the office of Rajiv Joseph, MD, PA to provide information about my treatment and medical condition to other healthcare providers and other routine healthcare operations such as assessing quality and reviewing competence of healthcare professionals. The following individuals may also receive information about my medical condition:

______________________________ ______________________________
Name Relationship | Name of your Primary Care Physician

______________________________ ______________________________
Name Relationship | Name Relationship

______________________________ ______________________________
Patient Signature Date | Printed Signature

____
Witness Date